SILIQ®
(brodalumab) injection
210 mg/1.5 mL

NEED ASSISTANCE?
Call [877-219-0059]
Monday-Friday, 9:00 AM-7:00 PM ET

SILIQ® Prescription Information & Enrollment Form

Your healthcare provider has determined that SILIQ may be an appropriate treatment option for you.

This enrollment form is a required step to support access to your prescribed therapy. Please review the instructions carefully and ensure that all sections are completed fully and accurately. Complete information helps prevent delays and allows your medication to be processed as efficiently as possible.

Form Completion & Submission Steps

PATIENT TO COMPLETE SECTIONS 1-3

1. Fill out all required sections (1-3 on pages 1-2) of the form indicated by a red asterisk *
2. There is one required signature indicated with a red flag SIGN & DATE
3. Submit to healthcare provider once your portion is complete—your healthcare provider will submit the form

HEALTHCARE PROVIDER TO COMPLETE SECTIONS 4-9

1. Fill out all required sections (4-9 on pages 3-4) of the form indicated by a red asterisk *
2. There is one required signature indicated with a red flag SIGN & DATE
3. **Submit pages 1-4 via FAX to Siliq Support at [877-219-0054], or to your Specialty Pharmacy of choice.**

This is a cover page and not to be filled or faxed by office.

Please see page 5 for Important Safety Information and click here for full Prescribing Information, including Boxed Warning about suicidal ideation and behavior.

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Prescription Information & Enrollment Form

NEED ASSISTANCE?
Call [877-219-0059]
Monday-Friday, 9:00 AM-7:00 PM ET

IMPORTANT: An incomplete form may delay the start of treatment. Please ensure all required fields marked with * are completed.

Patient Name* | Date of Birth* (MM/DD/YYYY)

FORM COMPLETION & SUBMISSION STEPS

1. Have patient fill and sign their portion of the form (Sections 1-3)
2. Healthcare professional to fill and sign their portion of the form (Sections 4-9)
3. Healthcare professional to provide a copy of fully completed form for patient's records
4. Healthcare professional to submit form via FAX to [877-219-0054]

PATIENT TO COMPLETE
Sections 1-3

Section 1 Patient Information

First Name* | Middle Initial | Last Name* | Date of Birth* (MM/DD/YYYY) | Sex Assigned at Birth* ☐ Female ☐ Male

Mailing Address* | City* | State* | ZIP Code*

Phone Number* | Email Address*

Communication Preferences*
I prefer to be contacted by (check all that apply): ☐ Phone ☐ Email ☐ Text Message (SMS)
Best time to contact me (check all that apply): ☐ Morning ☐ Afternoon ☐ Evening

Authorized Patient Representative Full Name | Relationship to Patient | Phone Number | Email Address

Is your shipping address different from your mailing address? ☐ Yes ☐ No If you answered "Yes", please fill in your shipping address below.

Shipping Address | City | State | ZIP Code

Section 2 Patient Insurance Information

Are you covered by insurance?* ☐ Yes ☐ No
If you answered "Yes" please fill in insurance information below.

If you are covered by insurance, you must include a photo of the front and back of your insurance card.

Primary Prescription Insurance Company Name* | Insurance Company Phone* | Employer*

Member ID #* | Group #* | BIN #* | PCN #*

Cardholder Name* | Relationship to Cardholder* | Cardholder Date of Birth (MM/DD/YYYY)

PATIENT SIGNATURE REQUIRED ON PAGE 2

Please see page 5 for Important Safety Information and click here for full Prescribing Information, including Boxed Warning about suicidal ideation and behavior.

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Call [877-219-0059]
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IMPORTANT: An incomplete form may delay the start of treatment. Please ensure all required fields marked with * are completed.

Patient Name* | Date of Birth* (MM/DD/YYYY)

PATIENT TO COMPLETE
Sections 1-3

Patients: Click to check for completion

Section 3 Patient Authorization & Consent

I understand that suicidal thoughts and behavior, including completed suicides, have occurred in patients treated with SILIQ®, and may occur at any time during treatment.
I will call my doctor or the National Suicide and Crisis Lifeline at **988** if:

- I feel new or worsening feelings of withdrawal, depression, anxiety, hopelessness, or other mood changes
- I am thinking about hurting or killing myself; seeking access to firearms, pills, or other means for the purpose of self-harm; or talking or writing about death and dying

I will call 911 if I feel an immediate threat of death or self-injury.

By signing this Patient Authorization Form, I confirm that I authorize my healthcare providers, pharmacies, and health plans to disclose my Protected Health Information ("PHI") related to the SILIQ Support such as my demographic information (e.g., name, address, phone number, health insurance), diagnosis, medical condition, treatment, and prescription information (e.g., dose, prior medications) to Bausch Health US, LLC and its agents and contractors ("Bausch Health"), and for Bausch Health to receive, use, and disclose my PHI to: 1) establish my eligibility for benefits through SILIQ Support; 2) communicate with my healthcare providers, health plans, and me about my medical care as it relates to SILIQ (brodalumab) injection, for subcutaneous use; 3) provide reimbursement and product support services including facilitating the provision of SILIQ to me; 4) contact me directly by phone, mail, or email and enroll me in SILIQ Support; 5) investigate, verify, assist with, and coordinate my coverage for SILIQ with my healthcare providers and health plan; 6) coordinate prescription fulfillment; 7) conduct analyses related to the quality, efficacy, and safety of SILIQ, as well as patient access and adherence to SILIQ; 8) provide my healthcare providers and me with educational materials, information, and services related to SILIQ.

I understand that my PHI will not be used or disclosed by Bausch Health for any other purpose unless permitted by applicable law or unless my personally identifiable information is removed. I understand that once my PHI has been disclosed to Bausch Health, federal privacy laws may no longer restrict its further disclosure.

I further understand that I may refuse to sign this Patient Authorization Form. My Healthcare Providers or Insurers will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits on my signing this Authorization Form. If I do not sign the Patient Authorization Form, or if I revoke this Authorization, I understand that I will not be able to participate in or receive assistance from SILIQ Support.

This Authorization will continue in effect until Bausch Health is no longer providing me with SILIQ Support or otherwise as required by state law. I have the right to revoke this Authorization at any time by calling SILIQ Support at [877-219-0059] or by contacting my healthcare providers or health plans, sending a letter to SILIQ Support at PO Box 592188, Orlando, FL 32859, or sending a fax to SILIQ Support at [877-219-0054]. If I revoke this Authorization, I understand that I will no longer be able to participate in the SILIQ Support programs. In addition, the revocation will prohibit further disclosures of my PHI to Bausch Health, but will not affect previous uses or disclosures of my PHI made in reliance on this Authorization. If the support services for SILIQ are discontinued, I understand that this Authorization will also end.

My signature below confirms I have read, understand, and agree to the Patient Authorization to release my Protected Health Information to Bausch Health US, LLC, its agents, and contractors, as described in the Patient Authorization.

Signature of Patient/Personal Representative* | Date (MM/DD/YYYY)*

SIGN & DATE

Print Name of Patient* | Print Name of Personal Representative | Personal Representative Relationship to Patient

☐ If you are signing as a legal representative of a patient, **check this box** to acknowledge that you are authorized to sign on behalf of the patient.

☐ **I agree** that I am a U.S. resident and give Bausch Health permission to send me information or contact me and/or my healthcare provider regarding my disease as well as information on other related treatments, products, and services, and for marketing and informational purposes by phone, email, or mail. I understand that Bausch Health will not sell my name, address, email address, or any other information to any other third party (other than Bausch Health's agents, service providers, contractors, and representatives) for their own marketing use. I understand that there is some risk that email communications could be intercepted or accessed by third parties, and consent to Bausch Health communicating with me via email in connection with the SILIQ Support.

☐ **I agree** to receive communications from Bausch Health (as defined above), including but not limited to calls made with an autodialer or prerecorded voice at the phone number(s) provided to provide me with insurance coverage and financial assistance resources and information, injection support, and for other non-marketing purposes. If I have designated a patient representative, he or she also agrees hereby to receive such communications from Bausch Health for the purposes described above at the phone number(s) provided. I understand that I (and, if applicable, my patient representative) can opt out of these communications at any time by mailing a letter, including my First Name, Last Name, Date of Birth, Gender, and ZIP Code, requesting such cancellation to SILIQ Support at PO Box 592188, Orlando, FL 32859, or sending a fax to SILIQ Support at [877-219-0054].

☐ **I understand** that by providing my consent to receive text messages from SILIQ Support, I agree to receive text messages related to ongoing support. Message and data rates apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in SILIQ Support and I can revoke my permission at any time.

Provide form to Healthcare Provider to complete and submit.

HCP INPUT REQUIRED ON PAGES 3 & 4

Please see page 5 for Important Safety Information and click here for full Prescribing Information, including Boxed Warning about suicidal ideation and behavior.

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(brodalumab) injection
210 mg/1.5 mL

Prescription Information & Enrollment Form

NEED ASSISTANCE?
Call [877-219-0059]
Monday-Friday, 9:00 AM-7:00 PM ET

⚠ **IMPORTANT:** An incomplete form may delay the start of treatment. Please ensure all required fields marked with * are completed.

Patient Name* | Date of Birth* (MM/DD/YYYY)

HEALTHCARE PROVIDER TO COMPLETE
Sections 4-9

Section 4 Prescriber Information

Prescriber First Name*
Prescriber Last Name*
Specialty*
Office Contact Name*
Practice Name*
Street Address*
City*
State*
ZIP Code*
Phone Number*
Fax Number*
Email Address*
NPI #*

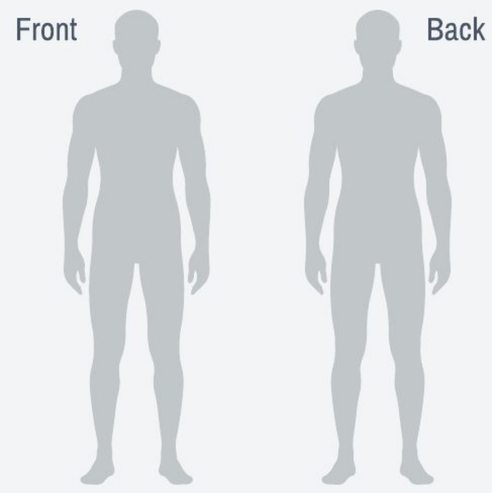
Section 5 Treatment Information

DIAGNOSIS: Plaque Psoriasis (L40.0)

Date of Diagnosis*
BSA (Body Surface Area) Affected %*
TB Test Date*
TB Test Result*

Has the prescription been sent to a pharmacy?* ☐ Yes ☐ No

Body Surface Areas Affected*



Section 6 Previous Failed Treatments*

☐ Bimzelx® ☐ Cimzia® ☐ Cosentyx® ☐ Enbrel® ☐ Humira® ☐ Icotyde™ ☐ Ilumya® ☐ Methotrexate ☐ Otezla®
☐ Remicade® ☐ Skyrizi® ☐ Stelara® ☐ Taltz® ☐ Tremfya® ☐ Phototherapy

Other
Other systemic therapy

Please see page 5 for Important Safety Information and click here for full Prescribing Information, including Boxed Warning about suicidal ideation and behavior.

HCP INPUT REQUIRED ON NEXT PAGE

SILIQ®
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210 mg/1.5 mL

Prescription Information & Enrollment Form

NEED ASSISTANCE?
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Monday-Friday, 9:00 AM-7:00 PM ET

⚠ **IMPORTANT:** An incomplete form may delay the start of treatment. Please ensure all required fields marked with * are completed.

Patient Name* _____ Date of Birth* (MM/DD/YYYY) _____

HEALTHCARE PROVIDER TO COMPLETE
Sections 4-9

Prescribers: Click to check for completion

Section 7 Prescription Information

Prescription only valid if received by fax. If not faxed, prescription must be submitted on state-specific form, if required for your state.

℞ SILIQ® (brodalumab) injection 210 mg/1.5 mL, for subcutaneous use
(1pk = QTY 2 Syringes)

Induction Dose:* ☐ 210 mg subcutaneous injection at weeks 0, 1, 2, 4. QTY: 4 syringes

Maintenance Dose:* ☐ 210 mg subcutaneous injection every 2 weeks. QTY: 2 syringes # of Refills* _____

Has the patient received a SILIQ® sample?* ☐ Yes ☐ No If you answered "Yes", supply date sample was given: (MM/DD/YYYY) _____

PRESCRIBER SIGNATURE REQUIRED TO VALIDATE PRESCRIPTION: I certify that I made the prescribing decisions indicated above based on my own independent medical judgment regarding what is in the best interest of the patient and that I have reviewed the current SILIQ Prescribing Information. By signing below, I confirm that: (1) I am certified as a healthcare provider under the SILIQ REMS Program, (2) I have counseled the patient on the risks of suicidal ideation and behavior that may occur with SILIQ, (3) the patient has signed the SILIQ REMS Patient-Prescriber Agreement, (4) I have given the patient the SILIQ REMS patient wallet card, and (5) I have enrolled the patient in the SILIQ REMS Program. I authorize Bausch Health US, LLC and its representatives to transmit this prescription to: the qualified pharmacy designated below, provided it is approved by the patient's plan; to a qualified pharmacy approved by this patient's plan if the qualified pharmacy designated is not a plan-approved pharmacy; any qualified pharmacy approved by this patient's plan if no qualified pharmacy is indicated.

Signature of Prescriber* _____ **Date (MM/DD/YYYY)*** _____

SIGN & DATE

☐ Dispense as Written

Section 8 Preferred Qualified Pharmacy

Pharmacies must be certified under the SILIQ REMS Program. A list of qualified pharmacies is available at SILIQREMS.com or by calling SILIQ Support at [877-219-0059]. As the treating physician, I have discussed preference for a qualified pharmacy with this patient, who prefers use of the qualified pharmacy indicated below.

Pharmacy Name _____ Phone Number _____ Fax Number _____

Section 9 Submit form

FORM SUBMISSION STEPS

1. Ensure all required information is completed, Sections 1-9.
2. Healthcare professional to provide a copy of completed form to patient for their records.

Submit pages 2-5 via FAX to Siliq Support at [877-219-0054], or to your Specialty Pharmacy of choice.

Simplify patient access with SILIQ Support

We are committed to helping your patients save on their SILIQ prescriptions.

Instant Savings Program >
https://www.siliq.com/savings-support/siliqsavings/

Patient Assistance Program >
https://bauschhealthpap.com

Please see page 5 for Important Safety Information and click here for full Prescribing Information, including Boxed Warning about suicidal ideation and behavior.

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IMPORTANT SAFETY INFORMATION

What is SILIQ?

SILIQ® injection is a prescription medicine used to treat adults with moderate to severe plaque psoriasis:

- who may benefit from injections or pills (systemic therapy) or phototherapy (treatment using ultraviolet light treatment) **and**
- who have tried another systemic therapy that didn't work or stopped working

It is not known if SILIQ is safe and effective in children.

What is the most important information I should know about SILIQ?

Suicidal thoughts and behavior: Some patients taking SILIQ have had suicidal thoughts or ended their own lives. This risk is higher if you have a history of suicidal thoughts or depression. It is not known if SILIQ causes these thoughts and actions. Get medical help right away or call the National Suicide and Crisis Lifeline at 988, if you or a family member notices that you have any of the following symptoms:

- new or worsening depression, anxiety, or mood problems
- thoughts of suicide, dying, or hurting yourself
- attempt to commit suicide, or acting on dangerous impulses
- other unusual changes in your behavior or mood

Because of your risk of suicidal thoughts and behavior during your treatment with SILIQ, SILIQ is available only through a restricted distribution program called the SILIQ Risk Evaluation and Mitigation Strategy (REMS). SILIQ can only be prescribed by a healthcare provider certified with the program. Your healthcare provider will give you a SILIQ patient/wallet card about symptoms that need medical attention right away. Carry the card with you during treatment with SILIQ and show it to all of your healthcare providers. SILIQ is only available through pharmacies that participate in the SILIQ REMS. Your healthcare provider can give you information about how to find a participating pharmacy. For more information, go to www.SILIQREMS.com or call 1-855-511-6135.

Serious Allergic Reactions: Get medical help right away if you get any of the following signs or symptoms of a serious allergic reaction including swelling of the face, lips, or tongue, trouble breathing or swallowing, itching, dizziness or feel faint, rash, hives, or redness all over your body, chest pain or tightness.

Serious Infections: SILIQ may lower the ability of your immune system to fight infections and may increase your risk of infections:

- Your healthcare provider should check you for tuberculosis (TB) before starting treatment with SILIQ and may treat you for TB before starting SILIQ if you have TB or a history of it
- You and your healthcare provider need to watch closely for **signs and symptoms of infection** during treatment with SILIQ, including fever, sweats, chills, shortness of breath, stomach issues, muscle aches, cough, sore throat or trouble swallowing, warm/red/painful skin sores, burning while urinating or more frequent urination than normal

Who should not use SILIQ? Do not use SILIQ if you are allergic to brodalumab or any of the ingredients in SILIQ or if you have Crohn's disease. Tell your healthcare provider if you develop diarrhea, bloody stools, stomach pain or cramping, sudden or uncontrollable bowel movements, loss of appetite, constipation, weight loss, fever or tiredness as these may be symptoms of Crohn's disease.

Before starting SILIQ, tell your healthcare provider if you:

- have a history of mental health problems, including suicidal thoughts, depression, anxiety, or mood problems
- have an infection that does not go away or keeps coming back
- have TB or have been in close contact with someone with TB
- have recently received or are scheduled to receive an immunization (vaccine). You should avoid getting live vaccines while being treated with SILIQ
- are or plan to become pregnant or are breastfeeding or plan to do so. It is unknown if SILIQ can harm your unborn or newborn baby

Tell your healthcare provider about all the medicines you take, including prescription and over-the-counter medicines, vitamins, and herbal supplements.

How should I use SILIQ?

See the detailed "Instructions for Use" that come with your SILIQ for information on the right way to store, prepare, and give your SILIQ injections at home, and how to properly throw away (dispose of) used SILIQ prefilled syringes. Use SILIQ exactly as your healthcare provider tells you to use it.

What are possible side effects of SILIQ?

SILIQ may cause serious side effects including severe skin reactions that look like eczema. These reactions can happen during treatment with SILIQ from days to months after your first dose and can sometimes lead to hospitalization. Your healthcare provider may temporarily stop treatment with SILIQ if you develop severe skin reactions. Tell your healthcare provider if you have any of the following signs or symptoms: redness or rash; itching; small bumps or patches; your skin is dry or feels like leather; blisters on the hands or feet that ooze or become crusty, or skin peeling.

See "What is the most important information I should know about SILIQ?" and "Who should not use SILIQ?"

The most common side effects of SILIQ include: joint pain, headache, tiredness, diarrhea, mouth or throat pain, nausea, muscle pain, injection site reactions, flu, low white blood count (neutropenia), and fungal infections of the skin. Call your doctor for medical advice on side effects. You are encouraged to report negative side effects of prescription drugs to Bausch Health US, LLC ("Bausch Health") at 1-800-321-4576 or FDA at 1-800-FDA-1088 or visit **www.fda.gov/medwatch**.

Please review full **Prescribing Information**, including Boxed Warning about suicidal ideation and behavior.

By providing your information and information about your patient on the front of the Prescription Information & Enrollment Form, you are requesting the services described on this form. The information you provide will only be used by Bausch Health, our affiliates, and our service providers, including SILIQ Support, involved in delivering these services. You may withdraw your request for these services by calling 877-219-0059. Our Privacy Policy, available at **https://www.bauschhealth.com/privacy**, governs the use of the information you provide. By providing the information and submitting this form, you indicate you read, understand, and agree to these terms.

Disclaimer

Patient insurance benefit investigation is performed by a Third Party, under contract for Bausch Health. The Third Party provides assistance in determining if treatment may be covered by the payer based on the payer's health plan guidelines and the patient information provided by you as authorized by the patient after your determination of medical necessity.

Verification of insurance coverage is the responsibility of the provider. Reimbursement by payers is subject to many factors. The Third Party and Bausch Health do not represent or guarantee that payer reimbursement or other payment will be made. The information provided as a result of the benefit investigation is provided for your information only. Although the Third Party makes every effort to be accurate in the information provided, no representations or warranties are expressed or implied by the Third Party and Bausch Health regarding the accuracy of the information. The Third Party and Bausch Health, and their respective agents or employees, shall not be liable for any costs or damages as a result of or related to patient support. Providers and additional users of this information accept responsibility for their use of the information.

Bausch Health does not assume responsibility for, nor guarantee the availability, scope, or quality of, the patient support services offered including reimbursement support, prescription fulfillment coordination, and other services. Providers are responsible for the services they provide, not Bausch Health. The patient support services are included within the cost of the product and have no value apart from the product.

PATIENT SECTION - Fields to complete:

- Patient Name (p2)
- Date of Birth (header p2)
- Patient Name (p3)
- Date of Birth (header p3)
- First Name
- Last Name
- Date of Birth
- Mailing Address
- City
- State
- ZIP Code
- Phone Number
- Email Address
- Signature of Patient/Personal Representative
- Date - Signature
- Print Name of Patient
- Communication Preferences: select Phone, Email, or Text
- Are you covered by insurance? (select Yes or No)

Please fill in all required fields before submitting.

OK

HCP SECTION - Fields to complete:

- Patient Name (p4)
- Date of Birth (header p4)
- Patient Name (p5)
- Date of Birth (header p5)
- Prescriber First Name
- Prescriber Last Name
- Specialty
- Office Contact Name
- Practice Name
- Street Address
- City (prescriber)
- State (prescriber)
- ZIP Code (prescriber)
- Phone Number (prescriber)
- Fax Number
- Email Address (prescriber)
- NPI #
- Date of Diagnosis
- BSA (Body Surface Area) Affected %
- TB Test Date
- TB Test Result
- # of Refills
- Signature of Prescriber
- Date (prescriber signature)
- Has prescription been sent to pharmacy? (select Yes or No)
- Has patient received a SILIQ sample? (select Yes or No)
- Previous Failed Treatments: check at least one or fill Other Therapies/Other Systemic
- Induction Dose or Maintenance Dose: select at least one

Please complete before submitting FAX to 877-219-0054.

OK